FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038679

Facility Name: Park Haven Care Center

Address: 107 South Lincoln (Number) Smithton (City) 62285 (Zip Code)

County: Saint Clair

Telephone Number: (618) 235-4600 **Fax #** (618) 235-5829

HFS ID Number: 95-2301514017

Date of Initial License for Current Owners: 12/31/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Greg LeRoy **Telephone Number:** (479) 201-4371

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/28/2006 (Date)
(Type or Print Name) Greg Swartz
(Title) Assistant Secretary

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	403	1,193		1,596	8
9	SNF/PED					9
10	ICF	27,302			27,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,705	1,193		28,898	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.39%

D. How many bed-hold days during this year were paid by the Department?
17 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Park Haven Care Center # 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	127,700	9,279	317	137,296		137,296	2,476	139,772			1
2	Food Purchase		106,111		106,111		106,111	(1,238)	104,873			2
3	Housekeeping		159	72,127	72,286		72,286	12	72,298			3
4	Laundry		2,853	48,085	50,938		50,938		50,938			4
5	Heat and Other Utilities			72,857	72,857		72,857	(3,141)	69,716			5
6	Maintenance	21,775	10,109	28,333	60,217		60,217	90	60,307			6
7	Other (specify):*			826	826		826	(60)	766			7
8	**TOTAL General Services**	149,475	128,511	222,545	500,531		500,531	(1,861)	498,670			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	800,016	27,574	39,444	867,034	23	867,057	1,130	868,187			10
10a	Therapy		23		23	(23)						10a
11	Activities	21,466	4,173	2,428	28,067		28,067	721	28,788			11
12	Social Services	131,798	1,490	3,243	136,531		136,531	(215)	136,316			12
13	CNA Training											13
14	Program Transportation			7,782	7,782		7,782	18	7,800			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	953,280	33,260	56,497	1,043,037		1,043,037	1,654	1,044,691			16
	C. General Administration											
17	Administrative			259,222	259,222	56,667	315,889	39,171	355,060			17
18	Directors Fees											18
19	Professional Services			850	850		850		850			19
20	Dues, Fees, Subscriptions & Promotions			26,456	26,456		26,456	(3,015)	23,441			20
21	Clerical & General Office Expenses	106,206	11,711	103,674	221,591	(56,667)	164,924	(55,151)	109,773			21
22	Employee Benefits & Payroll Taxes			225,515	225,515		225,515	(35,328)	190,187			22
23	Inservice Training & Education			3,556	3,556		3,556	(90)	3,466			23
24	Travel and Seminar			5,710	5,710		5,710	447	6,157			24
25	Other Admin. Staff Transportation			3,549	3,549		3,549		3,549			25
26	Insurance-Prop.Liab.Malpractice			141,595	141,595		141,595	91,877	233,472			26
27	Other (specify):*											27
28	**TOTAL General Administration**	106,206	11,711	770,127	888,044		888,044	37,911	925,955			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,208,961	173,482	1,049,169	2,431,612		2,431,612	37,704	2,469,316			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Haven Care Center #0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,024	67,024		67,024	(26,499)	40,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			51,080	51,080		51,080	3,226	54,306			33
34	Rent-Facility & Grounds			187,764	187,764		187,764		187,764			34
35	Rent-Equipment & Vehicles			16,139	16,139		16,139	(68)	16,071			35
36	Other (specify):*			19,528	19,528		19,528		19,528			36
37	**TOTAL Ownership**			341,535	341,535		341,535	(23,341)	318,194			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,174		13,174		13,174	(13,174)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							55,298	55,298			42
43	Other (specify):*		4,431		4,431		4,431	(4,431)				43
44	**TOTAL Special Cost Centers**		17,605		17,605		17,605	37,693	55,298			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,208,961	191,087	1,390,704	2,790,752		2,790,752	52,056	2,842,808			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,380)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,861)	21		24
25	Fund Raising, Advertising and Promotional	(2,396)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(147)	20		28
29	Other-Attach Schedule	(48,052)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,858)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	43,327	17	34
35	Other- Attach Schedule	107,587		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 150,914		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 52,056		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Haven Care Center

ID# 0038679

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Haven Care Center **#** 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	553	1,923	0	0	0	0	0	0	0	0	0	2,476	1
2	Food Purchase	(1,238)	0	0	0	0	0	0	0	0	0	0	(1,238)	2
3	Housekeeping	12	0	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,141)	0	0	0	0	0	0	0	0	0	0	(3,141)	5
6	Maintenance	90	0	0	0	0	0	0	0	0	0	0	90	6
7	Other (specify):*	(60)	0	0	0	0	0	0	0	0	0	0	(60)	7
8	**TOTAL General Services**	(3,784)	1,923	0	0	0	0	0	0	0	0	0	(1,861)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7,838)	8,968	0	0	0	0	0	0	0	0	0	1,130	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	721	0	0	0	0	0	0	0	0	0	0	721	11
12	Social Services	(227)	12	0	0	0	0	0	0	0	0	0	(215)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	18	0	0	0	0	0	0	0	0	0	0	18	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,326)	8,980	0	0	0	0	0	0	0	0	0	1,654	16
	C. General Administration													
17	Administrative	1,703	37,468	0	0	0	0	0	0	0	0	0	39,171	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,015)	0	0	0	0	0	0	0	0	0	0	(3,015)	20
21	Clerical & General Office Expenses	(48,404)	(6,747)	0	0	0	0	0	0	0	0	0	(55,151)	21
22	Employee Benefits & Payroll Taxes	(35,328)	0	0	0	0	0	0	0	0	0	0	(35,328)	22
23	Inservice Training & Education	(90)	0	0	0	0	0	0	0	0	0	0	(90)	23
24	Travel and Seminar	447	0	0	0	0	0	0	0	0	0	0	447	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	91,877	0	0	0	0	0	0	0	0	0	0	91,877	26
27	Other (specify):*	(1,703)	1,703	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	5,487	32,424	0	0	0	0	0	0	0	0	0	37,911	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,623)	43,327	0	0	0	0	0	0	0	0	0	37,704	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Park Haven Care Center **#** 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(26,499)	0	0	0	0	0	0	0	0	0	0	(26,499)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	3,226	0	0	0	0	0	0	0	0	0	0	3,226	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(68)	0	0	0	0	0	0	0	0	0	0	(68)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(23,341)	0	0	0	0	0	0	0	0	0	0	(23,341)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(13,174)	0	0	0	0	0	0	0	0	0	0	(13,174)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	55,298	0	0	0	0	0	0	0	0	0	0	55,298	42
43	Other (specify):*	(4,431)	0	0	0	0	0	0	0	0	0	0	(4,431)	43
44	**TOTAL Special Cost Centers**	37,693	0	0	0	0	0	0	0	0	0	0	37,693	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,729	43,327	0	0	0	0	0	0	0	0	0	52,056	45

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services	100	More than 340 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Stategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, Inc.	Fort Smith, AR	Nursing Staffing
				CSMS, Inc.	Fort Smith, AR	Purchasing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	017	Home Office Costs	$ 240,972	Beverly Health & Rehabilitation Services	100.00%	$ 278,440	$ 37,468	1
2	V	010	Nursing Consultant	34,286	Beverly Health & Rehabilitation Services	100.00%	43,254	8,968	2
3	V	001	Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	1,923	1,923	3
4	V	012	Housekeeping Consultant	0	Beverly Health & Rehabilitation Services	100.00%	12	12	4
5	V								5
6	V	10a	Therapy Expense/Home Office	0	Aegis Therapies, Inc.	100.00%	0		6
7	V	027	Home Office Costs	0	Ceres Strategies, Inc.	100.00%	1,703	1,703	7
8	V	021	Home Office Costs	33,712	Aedon Staffing, Inc.	100.00%	26,965	(6,747)	8
9	V	010	Home Office Costs	0	CSMS, Inc.	100.00%	0		9
10	V	002	Home Office Costs	0	CSMS, Inc.	100.00%	0		10
11	V	035	Home Office Costs	0	CSMS, Inc.	100.00%	0		11
12	V								12
13	V								13
14	Total			$ 308,970			$ 352,297	$ * 43,327	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehabilitation Services
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (479) 201-2000
Fax Number: (479) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corp Home Office/Admin	Resident Days	85,170	3	$ 820,153	$ 418,970	28,915	$ 278,440	1
2										2
3										3
4	10	Corp QA Cost - Nursing	Resident Days	85,170	3	127,406	99,796	28,915	43,254	4
5										5
6	01	Corp QA Cost - Dietary	Resident Days	85,170	3	5,664	4,120	28,915	1,923	6
7										7
8	12	Corp QA Cost - Housekeeping	Resident Days	85,170	3	34	27	28,915	12	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 953,257	$ 522,913		$ 323,629	25

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Non-Care Related Interest		X	Working Capital								6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,457 Line # 34

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Park Haven Care Center **#** 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 24,101	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 54,306	2
3. Under or (over) accrual (line 2 minus line 1).	$ 30,205	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 24,101	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 54,306	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	42,505	8
	2001	44,459	9
	2002	46,565	10
	2003	47,640	11
	2004	54,306	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Haven Care Center COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 0038679

CONTACT PERSON REGARDING THIS REPORT Greg LeRoy

TELEPHONE (479) 201-4371 FAX #: (479) 201-4302

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-33.0-113-004	Encore Park Haven IL LLC	$ 54,306.00	$ 54,306.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,306.00	$ 54,306.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,282 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	LEASEHOLD IMPROVEMENTS			1993	52,443	483	5-20	483		50,907	10
11	(See depreciation schedule for asset detail of items acquired 1993 - 2001)			1994	27,057	219	5-20	219		26,276	11
12				1995	13,241	794	5-20	794		9,863	12
13				1996	2,711	198	5-20	198		1,811	13
14				1997	100,410	8,927	5-20	8,927		75,185	14
15				1998	20,749	1,245	5-20	1,245		9,164	15
16				1999	8,584	545	5-20	545		5,382	16
17				2000	8,561	605	5-20	605		3,336	17
18				2001	63,250	6,325	5-20	6,325		28,427	18
19											19
20	REPL COMPRESSOR-ROOFTOP AC			2002	943	63	15	63		231	20
21	WALK IN COOLER/FREEZER			2002	8,776	585	15	585		2,145	21
22	KEYPAD			2002	600	40	15	40		143	22
23	3 DROPS			2002	970	65	15	65		226	23
24	CONTRUCTION INTEREST			2002	103	7	15	7		24	24
25	FIXED EQUIPMENT-15 YEAR LIFE			2002	22,089	1,473	15	1,473		5,154	25
26											26
27											27
28											28
29	CONTRACTOR PAY REQUESTS			2003	48,533	3,236	15	3,236		9,167	29
30	REPL CONDENSING COIL/HVAC			2003	945	63	15	63		152	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PRIVACY FENCE W/GATES,LIGH	2004	$ 5,941	$ 743	8	$ 743	$	$ 1,361	37
38	WM ALARM PANEL, INSTALL	2004	3,511	351	10	351		556	38
39	HEAT PUMP, AIR HANDLER,INS	2004	5,250	525	10	525		788	39
40	15 VANITY CABINETS & TOPS	2004	2,052	137	15	137		194	40
41	OUTLETS,BREAKER/CARE TRACK	2004	2,342	117	20	117		156	41
42	GARBAGE DISPOSAL,INSTALL	2004	1,024	205	5	205		273	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51	IAR COMPRESSOR/SPRINKLER S	2005	1,890	95	15	95		95	51
52	VINYL FLOORING/DINING ROOM	2005	4,464		1.666667				52
53	DEPOSIT:WINDOW REPLACEMENT	2005	198		1.666667				53
54	WATER HEATER,EXP TANK,INST	2005	6,495		1.583333				54
55	2 WINDOW REPL/INSTALL-BALA	2005	396		1.583333				55
56	33 WINDOW REPLACEMENTS	2005	26,726		1.5				56
57	2BREAKERS,2CIRCUITS,INSTAL	2005	1,619		1.416667				57
58	INSTALL/WATER HEATER	2005	172		1.416667				58
59	2 DROPS	2005	525		1.416667				59
60	SHOWER ROOM AND TUB RENOVA	2005	7,070		1.083333				60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 449,641	$ 27,044		$ 27,044	$	$ 231,017	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 192,046	$ 13,300	$ 13,300	$	5-10	$ 130,245	71
72	Current Year Purchases	9,165	181	181		5-10	180	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 201,211	$ 13,481	$ 13,481	$		$ 130,425	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 650,852	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,525	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,525	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 361,442	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		101	12/31/1985	$ 187,764	5	30	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 187,764 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purchase of all Encore facilities *

10. Effective dates of current rental agreement:
Beginning 12/31/2001
Ending 12/31/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 199,464
13.		$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2000 Ford Windstar	$ 340.42	$ 4,085	17
18					18
19					19
20					20
21	TOTAL		$ 340.42	$ 4,085	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Park Haven Care Center **#** 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,966	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,719)	324,934		3
4	Supply Inventory (priced at Historical Cost)	15,207		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	37,906		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 382,013	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	126,605		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	449,641		15
16	Equipment, at Historical Cost	201,211		16
17	Accumulated Depreciation (book methods)	(361,442)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 416,015	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 798,028	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 53,551	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,461		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,424		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,067		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Contingencies			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 132,503	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	1,094,902		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,094,902	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,227,405	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (429,377)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 798,028	$	48

***(See instructions.)**

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,170	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,170	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(442,547)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (442,547)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (429,377)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,400,968	1
2	Discounts and Allowances for all Levels	(62,673)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,338,295	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,380	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,497	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	918	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,795	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Pat Pers Needs, Other Misc. Rev	1,115	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,115	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,348,205	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	500,531	31
32	Health Care	1,043,037	32
33	General Administration	888,044	33
	B. Capital Expense		
34	Ownership	341,535	34
	C. Ancillary Expense		
35	Special Cost Centers	(37,693)	35
36	Provider Participation Fee	55,298	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,790,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	(442,547)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (442,547)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,668	1,840	$ 50,217	$ 27.29	1
2	Assistant Director of Nursing	612	620	15,013	24.22	2
3	Registered Nurses	2,661	3,101	111,216	35.87	3
4	Licensed Practical Nurses	12,418	13,434	222,386	16.55	4
5	CNAs & Orderlies	33,259	35,500	311,622	8.78	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,917	2,058	19,104	9.28	9
10	Activity Assistants	359	366	2,201	6.01	10
11	Social Service Workers	9,520	10,253	131,798	12.85	11
12	Dietician	295	295	6,498	22.06	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	11,498	12,382	93,430	7.55	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,907	2,171	22,447	10.34	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,736	1,784	56,667	31.76	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	5,340	5,975	76,915	12.87	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,398	3,800	46,119	12.14	31
32	Other Health Ca MDS Coordinator	1,865	2,223	43,328	19.49	32
33	Other(specify) DSD Cooridnator	0	0	0		33
34	TOTAL (lines 1 - 33)	88,453	95,801	$ 1,208,961 *	$ 12.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 284	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		6,012	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,428	11-3	44
45	Social Service Consultant		3,243	12-3	45
46	Other(specify) Hskpg/Laundry		120,212	3,4	46
47	Maintenance, Other Admin, Lab		53,105	6	47
48	Profess,MedWaste, Transport		927	6,19	48
49	TOTAL (lines 35 - 48)		$ 189,811		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY LOWE	Executive Director	0	$ 28,109
BECKY GARCIA	Executive Director	0	28,558
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,667

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Corporation Service Co. Inc.	Legal	$ 0
HR Solutions	Human Resource	370
Deloitte & Touche, LLP.	Accounting	480
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 850

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,557
Unemployment Compensation Insurance	0
FICA Taxes	0
Employee Health Insurance	45,594
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Injury	0
Payroll Taxes	118,607
Retirement Expense	0
Employee Fringe Benefits	3,429
Rounding	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 190,187

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,090
Advertising: Employee Recruitment	13,916
Health Care Worker Background Check	1,296
(Indicate # of checks performed 0)	
Dues, Subscriptions, & License	6,399
Advertising and Public Relations	3,655
Community Education	8
Contributions	1,838
Reclass Miscoded Expense	0
Less: PAC Fees/Contributions	
Less: Public Relations Expense	( )
Non-allowable advertising	(5,761)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,441

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,927
Meals	3,230
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,157

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Haven Care Center # 0038679 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Haven Care Center # 0038679 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association** **$3,737**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **282** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,298**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,380**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Beverly is a publicly traded company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.